Brownsville Community Development Corporation

☐ BMS @ 592
592 Rockaway Ave
Bklyn New York 11212
718 345-5000

☐ BMS @ Jefferson SBHC
400 Pennsylvania Ave
Bklyn New York 11207
718 495-7239

☐ BMS @ GENESIS
360 Snediker Ave
Bklyn New York 11207
718 922-2090

☐ BMS @ BRISTOL
259 Bristol Street
Bklyn New York 11207
646 459-9400

☐ BMS@ASHFORD
650 Ashford St
Bklyn, New York 11207
718 345- 5000

☐ BMS DENTAL@ GENESIS
330 Hinsdale St.
Bklyn, New York 11207
347 505-0801

PATIENT REGISTRATION AND GENERAL CONSENT FORM

DEMOGRAPHIC INFORMATION:

Last Name:_____ **First Name**_____ **Maiden Name** _____

Middle Name:_____ **Other Name**_____ **Date of Birth** (MM/DD/YYYY) _____

Social Security #_____ **Home Telephone** _____ **Mobile Phone** _____

Address:_____ **Apt#**_____ **City/State**_____ **Email Address** _____

I consent to receive email regarding my appointments. **YES** ☐ **NO** ☐
I consent to receive text messages regarding my appointments. **YES** ☐ **NO** ☐

LANGUAGE OF PREFERENCE: ☐ English ☐ Spanish ☐ Creole/French

RACE: ☐ Black/African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Native Hawaiian American Indian/Alaska Native ☐ Other Pacific Islander ☐ More than one Race ☐ Prefer Not to Disclose

ETHNICITY: ☐ Hispanic /Latino ☐ Non-Hispanic/Latino ☐ Refuse to Report ☐ Other

SEXUAL IDENTITY: ☐ Lesbian or Gay ☐Straight (not Lesbian or Gay) ☐ Bisexual ☐ Other ☐ Don't know ☐ Prefer not to disclose

GENDER IDENTITY: ☐ Male ☐ Female ☐ Transgender Male /Female to Male ☐Transgender Female/Male to Female ☐ Prefer Not to Disclose

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner ☐ Prefer Not to Disclose

ASSIGNED SEX at BIRTH: ☐ Male ☐ Female ☐ Choose not to Disclose ☐ Unknown

FINANCIAL DATA: Family Size:_____ Family Income:_____

☐ **MINOR** ☐ **UNEMPLOYED** ☐ **RETIRED** ☐ **OTHER**_____ **OCCUPATION** _____

EMPLOYER BUSINESS ADDRESS _____ BUSINESS PHONE _____

THIRD PARTY PAYMENT INFORMATION: Insurance Name:_____ Seq.#_____

Insurance No._____ Date of Expiration_____ Copayment Amt._____

Insurance Relation: Insured Date of Birth (mm/dd/yy)_____ Insured Name_____

☐ Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other _____

CONSENT: I hereby authorize the BMS Family Health Center to administer such medications and immunizations and to perform such diagnostic procedures as may be necessary for proper health and dental care.

Signed_____ **Date**_____

Pregnant Minor's Signature_____ **Date** _____

GUARDIAN INFORMATION:

IF MINOR, SIGNATURE OF GUARDIAN_____ **RELATIONSHIP TO PATIENT**_____ **DATE**_____

IN CASE OF EMERGENCY, NOTIFY: **Name**_____ **Address**_____

Relationship_____ **Telephone**_____

HOUSEHOLD INFORMATION

Type of Household - Please Select One :

1. Single(+18)	5. Foster Child	8. Widow/Widower
2. Single +18 w/child	6. Child unattach –18	9. W/Sig. Other
3. Married	7. Child HD of hshld (-18)	10. W/Sig. Other +Child
4. Married w/children		

Agricultural Worker – Select One:

1. Migrant	2. Seasonal	

Living Arrangements (if homeless) - Please Select One :

1. Shelter	3. Doubling Up	5. Other
2. Transitional	4. Street	6. Unknown

Reason for Homelessness - Please Select One:

:

1. Eviction	4. Abuse	7. Physical Impairment
2. Unemployment	5. Mental Impairment	8. Other
3. Disaster displacement	6. Substance Abuse	

Source of Income - Please Select One:

1. Employment	5. SSA	9.Pension/Retrmt. Benefits
2. AFDC	6. Unemployment	10. VA Benefits
3. SSD SSI	7. Workers Comp.	11. Alimony/Child Suprt.
4. None	8. Other	

Referred by - Please Select One:

1. Advertisement	3. Primary Care Physician	5. Insurance Co.
2. Self-Referral	4. Word of Mouth	6. Hospital
7. Patient in the Practice	8. Other	

Interpretation Services Needed? (Y/N): _____

Print Name:_____Signature:_____Date: _____

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Parent/Guardian Authorization Form for Utilization of Services:

I, _____, the Parent/Guardian or and Authorized Legal Representative, hereby give permission for my child to be seen for medical services at this Facility accompanied by one of the following person(s) named below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Please note that all authorized representatives accompanying child are required to present a valid picture ID.

This form MUST be updated Annually:

Thank you for choosing BMS – You Come First, We Make it Easy

Brownsville Multi-Service Family Health Center
592 Rockaway Avenue, NY 11212-5539 (718) 345-5000 Fax (718) 345-5794

Patient Name:_____ Chart #:_____

Thank you for choosing BMS as your healthcare facility. We are committed to provide and promote integrative and high quality medical, dental, and social services to enable every individual and family to achieve total health.

OFFICE VISITS & OFFICE SERVICES:

Please be advised payment of your bill is part of your treatment and care.

You are responsible for payment of any deductible, co-payment and/or co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. Upon request, a member of our Patient Services staff will connect you with your insurance to discuss any deductibles and out of pocket expenses you are responsible for as outlined by your insurance plan. Providers are prohibited from charging any additional amount for a service billed to the Medicaid and Medicare program. We cannot charge additionally for treatment services that are not covered by the program; or are more costly without entering into a written *"private pay arrangement"* before treatment which precludes any payment by the Medicaid and Medicare program. For Managed Care participants, you may have to pay for any service that your Primary Care Physician (PCP) does not approve. Also, prior to services rendered, if you agree to be a "private pay" or "self-pay" patient you will have to pay for the service. This includes non-covered services (defined in your plan member handbook), unauthorized services and services by provider not part of your insurance plan.

HOW MAY I PAY?

We accept payment by Cash, VISA, MasterCard, Discover or American Express with a copy of a valid photo ID.

ACKNOWLEDGEMENT:

I have read, understand, and agree to the above Payment Policy. I understand that my co-payment, co-insurance and/or deductibles are due and payable at the time of service. I understand I must be knowledgeable of my insurance coverage, exclusions, and my responsibilities.

- I authorize my insurance benefits be paid directly to Brownsville Community Development Corporation d/b/a BMS Family Health Center.

_____ _____ _____

Date Patient's Name (Please Print) Patient/Guardian's Signature

_____ _____

Date Patient Service Representative Signature

Brownsville Community Development Corporation

☐ BMS@592	☐ BMS@HWC	☐ BMS@Jefferson SBHC	☐ BMS@GENESIS	☐ BMSISIS@BRISTOL
592 Rockaway Ave Bklyn New York II212 718 345-5000	116 Williams Ave Bklyn New York 11207 718 495-7239	400 Pennsylvania Ave Bklyn NewYork 11207 718 922-2090	360 Snediker Ave Bklyn New York 11207 646 459-9400	259 Bristol Street Brooklyn,New York 11212 718 345- 5000

CHART # _____ DATE: _____

Authorized Requester Form

I _____, of _____
Patient Address

do authorize _____, _____
Name Relationship to Patient

to request in my name, and place, in any way which I myself could do,

if I were personally present to execute a HIPAA medical record

Authorization form for my Protected Health Information.

PLEASE NOTE: This authorization may be revoked by me at any time.

Patient Signature_____ Date_____

Authorized Requester's _____Date_____
Signature

Authorized Requester's _____
Address

Authorized Requester's _____
Telephone #

Authorized Requester Picture ID on file Yes _____
Please circle

Please note that all authorized requesters are required to present a valid Picture ID.

BROWNSVILLE MULTI SERVICE FAMILY HEALTH CENTER
592 ROCKAWAY AVENUE BROOKLYN NEW YORK 11212
HIPAA PRIVACY RULE COMPLIANCE

FORM OF CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT INFORMATION: Patient Name: _____

Patient Address: _____

_____

Patient's Telephone Number: _____

Social Security Number: _____

Patient Medical Record Number: _____

Acknowledgment of Receipt: I, the undersigned patient or other person legally authorized to act for the patient, have been provided with a copy of ***the Notice of Privacy Practices for Protected Health Information***, and I have had the right to review the ***Notice*** prior to signing this ***Consent.***

Consent for Use and Disclosure of Protected Health Information: I, the undersigned patient or other person legally authorized to act for the patient, understand and agree that all health information concerning the above-named patient ("***Protected Health Information***") shall remain the property of Brownsville Multi Service Family Health Center. I consent to the use and disclosure of such Protected Health Information as described in Brownsville Multi Service Family Center's ***Notice of Privacy Practices for Protected Health Information***. Except for the reasons described in the ***Notice***, I may revoke this *Consent* in writing at any time using the procedure in the ***Notice.***

This is to certify that I, the undersigned patient or other person legally authorized to act for the patient, have read this ***Consent for Use and Disclosure of Protected Health Information and Acknowledgment of Receipt of Notice of Privacy Practices***, understand its content, and accept its terms. I agree that this ***Consent*** supercedes any and all previous consents, authorizations, releases, and other written legal permissions signed by me regarding use and disclosure of the Protected Health Information covered by this ***Consent***, and I release Brownsville Multi Service Family Health Center and its health care providers from all liabilities related to their compliance with this ***Consent.***

Signature of Patient or Patient's Parent, Guardian, or Other Authorized Legal Representative:

_____

Printed Name of Patient's Representative: _____

Basis of Authority to Act for Patient: Patient ☐ Parent ☐ Guardian ☐ Representative ☐

Address of Patient's Representative: _____

Telephone Number of Patient's Representative: _____

Date: _____

FORM A

PLEASE COMPLETE THIS FORM AND GIVE THE WHOLE BOOKLET TO REGISTRATION CLERK

Health Care Proxy

1) I,_____
hereby appoint _____
(name, home address and telephone number)
_____
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____
_____
_____

(Unless your agent knows wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of language you could use.)

3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(name, home address and telephone number)
_____

4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific dates or conditions, if desired):

_____

5) Signature _____
Address _____
Date _____

Statement by Witness (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____
Address _____
Witness 2 _____
Address _____

PLEASE COMPLETE THIS FORM AND GIVE THE WHOLE BOOKLET TO REGISTRATION CLERK

PLEASE COMPLETE THIS FORM AND GIVE THE WHOLE BOOKLET TO REGISTRATION CLERK

FORM B

Name: _____

Chart: _____

DOB: _____

DATE: _____

ACKNOWLEDGEMENT OF PATIENT RIGHTS INFORMATION

In accordance with New York State Department of Health and Federal Law Part 405.7, the above-named patient has received a booklet on "YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT."

The booklet is divided into two sections:

Section I: Explains your rights as a hospital/health center patient in New York State.

Section II: Presents each document that the law requires you to receive as a patient in a hospital/health center in New York State.

The affixed signature of the patient, or patient's significant other, and the health center representative are evidence that the above information was given to the patient. In addition, I have been informed that Brownsville Multi-Service Family Health Center is a non-smoking facility.

COMMENTS:

A) Patient has an Advance Directive	O Yes O No
*( ) Copy placed on chart	
( ) Patient/Family/Other requested to bring in	
( ) Re-done	
B) Patient is requesting further explanation on Advance Directive	O Yes O No
C) Patient would like to execute an Advance Directive	O Yes O No

FOLLOW-UP:

_____

_____

_____

SIGNATURE OF PATIENT:	
NAME OF BMS REPRESENTATIVE (Print):	SIGNATURE OF BMS REPRESENTATIVE: